

## (A) MEDICAL PROGRAMS

- All Employees (excluding employees in the IBEW Union hired prior to 8/1/06)
- Non-Medicare-Eligible Retirees (excluding IBEW employees who retired between 8/1/00 and 7/31/06)
- Non-Medicare-Eligible Participants on LTD (excluding IBEW LTDs terminated between 8/1/00 and 7/31/06)

	CIGNA OAP (PPO)			Vytra PPO		
	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Aetna (HMO)</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>HIP (HMO)</b>
<b>Medical Care Provider</b>	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/facility	Participating physician/facility
<b>Payment of Benefits</b>	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
<b>Age Limit for Dependent Children/Full-Time Student</b>	To age 19/ End of the year age 23	To age 19/ End of the year age 23	End of the month age 19/End of the year age 23	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23
<b>Annual Deductible (Indiv/Family)</b>	N/A	\$500/\$1,500	N/A	N/A	\$2,000/\$4,000	N/A
<b>Annual Out-of-Pocket Maximum (Individual/Family) (Excl Deductible)</b>	N/A	\$2,500/\$7,500	\$1,500/\$3,000	N/A	\$5,000/\$10,000	N/A
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>Pre-Existing Condition Limitation</b>	N/A	N/A	N/A	N/A	N/A	N/A
<b>Office Visits</b>	Covered in full after \$20 co-pay PCP/\$30 co-pay Specialist	80% of R&C after deductible	Covered in full after \$20 co-pay PCP/\$25 co-pay Specialist	Covered in full after \$20 co-pay PCP/\$30 co-pay Specialist	70% of R&C after deductible	Covered in full after \$20 co-pay PCP/\$30 co-pay Specialist
<b>Emergency Room (Accident/Illness)</b>	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after \$50 co-pay (waived if admitted)	Emergency: Covered in full after \$50 co-pay (waived if admitted) Non-emergency: only covered out-of-network: 70% of R&C after deductible		Covered in full after \$50 co-pay (waived if admitted)
<b>Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)</b>	Covered in full Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	Covered in full Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	70% of R&C after deductible	Covered in full
(Physician/Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
<b>Second Surgical Opinion (Office Visit)</b>	Covered in full	100% of R&C	Covered in full after \$25 co-pay	Covered in full after \$30 co-pay	100% of R&C	Covered in full
<b>Laboratory/X-Ray</b>	Covered in full	80% of R&C after deductible	Covered in full after \$25 co-pay	Covered in full	70% of R&C after deductible	Covered in full after \$20 co-pay
<b>Maternity (Initial Visit To Determine Pregnancy)</b>	Covered in full after \$20 co-pay	80% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full after \$20 co-pay	70% of R&C after deductible	Covered in full after \$20 co-pay
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
<b>Prescription Medication (Retail)</b>	*\$10 generic/ \$25 brand formulary \$40 brand non-formulary (up to 30-day supply)	Must use in-network pharmacy	\$10 generic/\$20 brand formulary/ \$40 brand non-formulary (up to 30-day supply)	*\$10 generic/ \$25 brand formulary/ \$40 brand non-formulary (up to 30-day supply)	In-network only	\$15 generic/\$30 brand formulary/ \$50 brand non-formulary (up to 30-day supply)
(Mail Order)	*\$20 generic/ \$50 brand formulary/ \$80 brand non-formulary (up to 90-day supply)	Must use in-network benefit	\$20 generic/\$40 brand formulary/ \$80 brand non-formulary (31 to 90-day supply)	*\$20 generic/ \$50 brand formulary/ \$80 brand non-formulary (up to 90-day supply)	In-network only	\$22.50 generic/\$45 brand formulary/ \$150 brand non-formulary (up to 90-day supply)

\*After meeting a \$100 per person/\$300 per family annual drug deductible

PCP = Primary Care Physician

R&C = Reasonable & Customary

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	CIGNA OAP (PPO)		Aetna (HMO)	Vytra PPO		HIP (HMO)
	In-Network	Out-of-Network		In-Network	Out-of-Network	
<b>Preventive Care</b> (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 17)	70% of R&C after deductible	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after \$20 co-pay	80% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full after \$20 co-pay	70% of R&C after deductible	Covered in full after \$20 co-pay
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full	70% of R&C after deductible	Covered in full after \$20 co-pay
(Physical Exam)	Covered in full after \$20 co-pay if by PCP	Not covered	Covered in full after \$20 co-pay PCP/\$25 co-pay Specialist	Covered in full after \$20 co-pay if by PCP	Not covered	Covered in full after \$20 co-pay if by PCP
(Routine Eye Exam)	Not covered	Not covered	Covered in full after \$25 co-pay	Covered in full after \$30 co-pay (1 exam/year)	Not covered	Covered in full (for optometrist in discount program)
<b>Mental Health Care</b> (Inpatient)	Same as inpatient hospital	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Same as inpatient hospital (Max: 30 days/year combined in/out)	Same as inpatient hospital	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after \$30 co-pay/visit	80% of R&C after deductible	Covered in full after \$25 co-pay/visit (Max: 20 visits/year)	Covered in full after \$30 co-pay (Max: 20 visits/year combined in/out)	70% of R&C after deductible	Covered in full after \$25 co-pay/visit (Max: 20 visits/year)
<b>Substance Abuse Treatment</b> (Inpatient Detox)	Same as inpatient hospital	Same as inpatient hospital	Covered in full	Same as inpatient hospital (Max: 3 periods/year combined in/out)	Same as inpatient hospital	Covered in full (Max: 7 days/year)
(Outpatient Rehab)	Covered in full after \$30 co-pay/visit	80% of R&C after deductible	Covered in full after \$25 co-pay/visit (Max: 60 visits/year)	Covered in full after \$30 co-pay/visit (Max: 60 visits/year combined in/out)	70% of R&C after deductible	Covered in full after \$25 co-pay/visit (Max: 60 visits/year)
<b>Alternate Care</b> (Home Health Care)	Covered in full (Max: 40 visits/year combined in and out of network)	80% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full (Max: 40 visits/year combined in/out)	70% of R&C after deductible	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility) Non-Custodial	Same as inpatient hospital (Max: 60 days/year combined in and out of network)	Same as inpatient hospital	Covered in full	Same as inpatient hospital (Max: 45 days/year combined in/out)	Same as inpatient hospital	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after \$30 co-pay	80% of R&C after deductible	Covered in full after \$25 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after \$30 co-pay (Max: 60 consecutive days/ injury/ lifetime combined in/out)	70% of R&C after deductible	Covered in full after \$30 co-pay (Max: 90 visits/year)
<b>Durable Medical Equipment</b>	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
<b>External Prosthetic Devices</b>	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	70% of R&C after deductible	Covered in full
<b>Hearing Aids</b>	Covered in full ----- (Max: \$2000/1095 days) -----	80% of R&C after deductible	Not covered	Not covered	Not covered	Not covered

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